APPLICATION FOR A LIMITED TEMPORARY PERMIT TO PRACTICE CHIROPRACTIC

State Form 51116 (4-03)
Approved by State Board of Accounts, 2002

HEALTH PROFESSIONS BUREAU
402 West Washington Street
Room W066
Indianapolis, Indiana 46204

*** Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

Temporary Permit Fee	
Date Fee Paid	
Receipt Number	
Permit Number	
Date Issued	

PHOTOGRAPH
Attach one (1) passport-quality photograph taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Address (*number and street or rural route*)	
City, state, ZIP code	
Date of birth	Place of birth
Telephone number (*daytime*)	Email address

CHIROPRACTIC SCHOOL OF GRADUATION

NAME OF SCHOOL	LOCATION (*City and State*)	DATE OF GRADUATION

CHIROPRACTIC LICENSES HELD

LIST ALL STATES INCLUDING INDIANA IN WHICH YOU HAVE BEEN LICENSED OR CERTIFIED TO PRACTICE CHIROPRACTIC

STATE	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE

PURPOSE FOR TEMPORARY PERMIT

1. What is the purpose for applying for a temporary permit?

PURPOSE FOR TEMPORARY PERMIT (*continued*)

2. What is the activity, organization, function, and event with regard to which the chiropractic services will be provided?

3. Specify type, extent, and specialization of chiropractic services to be provided.

LOCATION AND DATES OF SERVICE

Name of practice	
Address (*number and street or rural route*)	
City, state, ZIP code	
Telephone number	Email address

DATES OF WHICH SERVICES WILL BE PROVIDED
A temporary permit is valid for a nonrenewable period of not more than thirty (30) days.

Beginning Date		**Ending Date**	

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Have you ever previously filed an application in the State of Indiana?	☐ Yes ☐ No
2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
3. Have you ever been denied a license, certificate, registration or permit to practice chiropractic or any regulated health occupation in any state (*including Indiana*) or country?	☐ Yes ☐ No
4. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
5. Have you been convicted of, plead guilty or nolo contendere to: A. A violation of a Federal, State, or local law relating to the use, manufacturing, distribution of dispensing of controlled substances or drug addition? B. Any offense, misdemeanor or felony in any state? (*Except for minor violation of traffic laws resulting in fines.*)	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, correct and complete.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for a chiropractic temporary permit.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information, which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of the authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to the same.

Signature of applicant	Date signed (*month, day, year*)

VERIFICATION OF CHIROPRACTIC STATE LICENSURE FOR A LIMITED TEMPORARY PERMIT

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Complete the top section. Make copies to send to each state where you hold or have held a license. Request the state(s) to complete and return directly to the:

Health Professions Bureau
Indiana Board of Chiropractic Examiners
402 West Washington Street
Room W066
Indianapolis, Indiana 46204

PLEASE TYPE OR PRINT

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Address (*number and street or rural route*)	
City, state, ZIP code	
Telephone number (*daytime*)	Email address
License number	Date of issuance

AUTHORIZATION

I hereby authorize the State of _____ to provide the following information to the Indiana Board of Chiropractic Examiners.

Signature of applicant	Date signed (*month, day, year*)

License number	**Date of issuance (*month, day, year*)**	**Expiration date (*month, day, year*)**

Has the license been subject to disciplinary action? (*Please attach copies of any disciplinary action taken by your board.*)
☐ Yes ☐ No

LICENSED BY

☐ **Examination** ☐ **Endorsement** ☐ **Other (*Please specify*)** _____

☐ **National Boards** ☐ **Part I** ☐ **Part II** ☐ **Part III** ☐ **Part IV** ☐ **Physiotherapy**

State Examination administered? ☐ Yes ☐ No	Date of examination (*month, day, year*)

NAME		**PLEASE AFFIX BOARD SEAL**
TITLE		
STATE BOARD		
DATE		